

		FOR OHF USE					

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0045427</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>St Joseph Home of Chicago</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/00</u> to <u>06/30/01</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>2650 North Ridgeway</u> <u>Chicago</u> <u>60647</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Cook</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) <u>Administrator</u>	
Telephone Number: <u>(773)235-8600</u> Fax # <u>(773)235-2933</u>		Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # ()	
IDPA ID Number: <u>361722080001</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
Date of Initial License for Current Owners: <u>06/3/59</u>			
Type of Ownership:			
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT			
<input checked="" type="checkbox"/> Charitable Corp.			
<input type="checkbox"/> Trust			
IRS Exemption Code _____			
<input type="checkbox"/> PROPRIETARY			
<input type="checkbox"/> Individual			
<input type="checkbox"/> Partnership			
<input type="checkbox"/> Corporation			
<input type="checkbox"/> "Sub-S" Corp.			
<input type="checkbox"/> Limited Liability Co.			
<input type="checkbox"/> Trust			
<input type="checkbox"/> Other _____			
GOVERNMENTAL			
<input type="checkbox"/> State			
<input type="checkbox"/> County			
<input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: Name: <u>Walena Valencia</u> Telephone Number: <u>(773)235-8600 X107</u>			

STATE OF ILLINOIS

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Facility Name & ID Number St Joseph Home of Chicago# 0045427 Report Period Beginning: 07/01/00 Ending: 06/30/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>173</u>	Skilled (SNF)	<u>173</u>	<u>63,318</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>173</u>	TOTALS	<u>173</u>	<u>63,318</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>2,405</u>	<u>200</u>	<u>3,843</u>	<u>6,448</u>	8
9	SNF/PED					9
10	ICF	<u>20,451</u>	<u>22,467</u>	<u>0</u>	<u>42,918</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>22,856</u>	<u>22,667</u>	<u>3,843</u>	<u>49,366</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 77.97%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

yesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 3/3/59

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter numberof beds certified 27 and days of care provided 3,843Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 6/30/01 Fiscal Year: 6/30/01

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

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Facility Name & ID Number

St Joseph Home of Chicago

0045427

Report Period Beginning:

07/01/00

Ending:

06/30/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	363,305		5,730	369,035	7,700	376,735		376,735		1
2	Food Purchase		345,642		345,642		345,642		345,642		2
3	Housekeeping	185,768			185,768		185,768		185,768		3
4	Laundry	105,097	12,153		117,250		117,250		117,250		4
5	Heat and Other Utilities			168,022	168,022		168,022		168,022		5
6	Maintenance	198,703		81,519	280,222		280,222		280,222		6
7	Other (specify):* Security & Waste			88,059	88,059		88,059		88,059		7
8	TOTAL General Services	852,873	357,795	343,330	1,553,998	7,700	1,561,698		1,561,698		8
	B. Health Care and Programs										
9	Medical Director					7,200	7,200		7,200		9
10	Nursing and Medical Records	2,711,279	412,282	35,059	3,158,620		3,158,620		3,158,620		10
10a	Therapy	179,858		11,536	191,394		191,394		191,394		10a
11	Activities	157,522	3,885	30,759	192,166	1,661	193,827		193,827		11
12	Social Services	93,730		941	94,671		94,671		94,671		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*			2,136	2,136		2,136		2,136		15
16	TOTAL Health Care and Programs	3,142,389	416,167	80,431	3,638,987	8,861	3,647,848		3,647,848		16
	C. General Administration										
17	Administrative			791,286	791,286		791,286	(323,892)	467,394		17
18	Directors Fees										18
19	Professional Services			207,644	207,644	(16,561)	191,083	(4,376)	186,707		19
20	Dues, Fees, Subscriptions & Promotions			8,490	8,490		8,490		8,490		20
21	Clerical & General Office Expenses	396,126	27,630	57,468	481,224		481,224		481,224		21
22	Employee Benefits & Payroll Taxes			839,718	839,718		839,718		839,718		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,182	1,182		1,182		1,182		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			109,693	109,693		109,693		109,693		26
27	Other (specify):*										27
28	TOTAL General Administration	396,126	27,630	2,015,481	2,439,237	(16,561)	2,422,676	(328,268)	2,094,408		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,391,388	801,592	2,439,242	7,632,222		7,632,222	(328,268)	7,303,954		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

St Joseph Home of Chicago

#0045427

Report Period Beginning:

07/01/00

Ending:

06/30/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			218,189	218,189		218,189		218,189			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			218,189	218,189		218,189		218,189			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			4,289	4,289		4,289		4,289			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			95,911	95,911		95,911		95,911			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			100,200	100,200		100,200		100,200			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,391,388	801,592	2,757,631	7,950,611		7,950,611	(328,268)	7,622,343			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number St Joseph Home of Chicago

0045427

Report Period Beginning: 07/01/00

Ending: 06/30/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(4,376)	19-3		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(323,892)	17-3		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (328,268)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (328,268)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

St Joseph Home of Chicago

ID# 0045427

Report Period Beginning: 07/01/00

Ending: 06/30/01

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

Summary A

06/30/01

06/30/01

[illegible]

Summary B

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

Facility Name & ID Number St Joseph Home of Chicago# 0045427

Report Period Beginning:

07/01/00

Ending:

06/30/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				FSCSC	Homewood	Religious/Mgmt

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17-3 Adminitrator Compensation	\$ 98,244	Franciscan Sisters of Chicago Service Corporation		\$ 98,244	\$	1
2	V	17-3 Information Technology	26,400	Franciscan Sisters of Chicago Service Corporation		26,400		2
3	V	17-3 Administrative & Training	211,131	Franciscan Sisters of Chicago Service Corporation		211,131		3
4	V	17-3 Other Services	6,562	Franciscan Sisters of Chicago Service Corporation		6,562		4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 342,337			\$ 342,337	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number St Joseph Home of Chicago# 0045427Report Period Beginning: 07/01/00Ending: 06/30/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number St Joseph Home of Chicago # 0045427 Report Period Beginning: 07/01/00 Ending: 06/30/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number St Joseph Home of Chicago # 0045427 Report Period Beginning: 07/01/00 Ending: 06/30/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization FSCSC
 Street Address 1055 W. 175thSt.,Ste.202
 City / State / Zip Code Homewood,IL 60430
 Phone Number (708)647-6500
 Fax Number (708)647-6982

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$	\$			\$	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$	\$			\$	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **St Joseph Home of Chicago**# **0045427** Report Period Beginning: **07/01/00** Ending: **06/30/01****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1. Real Estate Tax accrual used on 2000 report.			\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For 19 _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	1996	8		
	1997	9		
	1998	10		
	1999	11		
	2000	12		
			FOR OHF USE ONLY	
			13	FROM R. E. TAX STATEMENT FOR 2000 \$ 13
			14	PLUS APPEAL COST FROM LINE 5 \$ 14
			15	LESS REFUND FROM LINE 6 \$ 15
			16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St Joseph Home of Chicago COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0045427

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

A.

Square Feet:

94,171

B. General Construction Type:

Exterior

Brick

Frame

Number of Stories

4

C.

Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D.

Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E.

List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F.

Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☐

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Patient Care		1928	\$ 12,325	1
2					2
3	TOTALS			\$ 12,325	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	173		1929	1929	\$ 377,812	\$	30	\$	\$	\$ 377,812	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9			1954		10,227		26			10,227	9
10			1955		5,952		25			5,952	10
11			1956		4,509		24			4,509	11
12			1958		14,846		41			14,846	12
13			1959		17,042		40			17,042	13
14			1963		35,827		20			35,827	14
15			1964		64,840		20			64,840	15
16			1966		59,466		20			59,466	16
17			1967		223,218		20			223,218	17
18			1968		237,183		20			237,183	18
19			1973		182,118		20			182,118	19
20			1974		231,457		20			231,457	20
21			1976		162,056		20			162,056	21
22			1977		1,136,934		20			1,136,934	22
23			1978		470		20			470	23
24			1982		9,434		10			9,434	24
25			1983		1,297,652		20			1,297,652	25
26			1984		409,810		15			409,810	26
27			1985		216,977		20			216,977	27
28			1986		6,710		10			6,710	28
29			1987		15,790		10			15,790	29
30			1988		66,942		20			66,942	30
31			1989		3,134		10			3,134	31
32			1990		273,817	13,691	20	13,691		243,519	32
33			1991		154,978	10,332	15	10,332		103,318	33
34		EMPLOYEE CAFE FIRE ALARM	1992		2,264	151	15	151		1,283	34
35		EMPLOYEE CAFE DUCT WORK	1992		5,839	292	20	292		2,482	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	EMERGENCY GENERATOR INSTALLATION	1992	\$ 83,803	\$ 5,587	15	\$ 5,587	\$	\$ 47,488		37
38	DUMB WATER REPAIR	1992	2,346	235	10	235		1,994		38
39	HOT & COLD WATER PRESSURE TANK	1992	35,760	1,788	20	1,788		15,198		39
40		1993	49,024	3,268	15	3,268		24,512		40
41	COMPLETION OF TRAYLINE-	Aug-94	47,708	3,181	15	3,181		20,673		41
42	CREDIT FOR TRAYLINE	Aug-94	(4,543)	(303)	15	(303)		(1,969)		42
43	CONCRETE & TUCKPOINTING NR NORTH	Sep-94	4,250	425	10	425		2,763		43
44	INSTALL ELECTRIC TRYLINE	Sep-94	2,475	165	15	165		1,073		44
45		Sep-94	9,027	451	20	451		2,934		45
46	TELEPHONE SYSTEM EQUIPMENT	Oct-94	6,499	650	10	650		4,224		46
47	EMERGENCY GENERATOR CONSULTATION	Jan-95	4,850	323	15	323		2,102		47
48	CHIMNEY REPAIR	Apr-95	618	41	15	41		268		48
49	CHIMNEY REPAIR	Jun-95	120	8	15	8		52		49
50	MASONRY REPAIR PROJECT	Jun-95	3,300	132	25	132		858		50
51	FIRE ALARM UPDATE	Jul-95	2,630	263	10	263		1,447		51
52	ROOFING	Jul-95	2,300	92	25	92		506		52
53	MASONRY REPAIR PROJECT	Oct-95	2,980	119	25	119		656		53
54	500 GALLON TANK SYSTEM	Nov-95	21,118	845	25	845		4,646		54
55	NETWORK CABLING	Dec-95	3,000	300	10	300		1,650		55
56	NEW PIPES AND PADDING	Dec-95	9,875	395	25	395		2,173		56
57	ENTRANCE CANOPY 3RD FLR ROOF, DECK	Jan-96	9,876	988	10	988		5,432		57
58	EMERGENCY BACK-UP GENERATOR	Jan-96	173,754	8,688	20	8,688		47,782		58
59	TEMPERATURE CONTROLS	Sep-96	1,552	155	10	155		699		59
60	OUTSIDE OF BUILDING MASONRY	Sep-96	41,500	1,660	25	1,660		7,470		60
61	ELECTRICAL WIRINGS	Nov-96	789	39	20	39		178		61
62	OUTSIDE OF BUILDING MASONRY	Dec-96	36,396	2,426	15	2,426		10,919		62
63	OUTSIDE OF BUILDING MASONRY	Jan-97	44,100	2,940	15	2,940		13,230		63
64	OUTSIDE OF BUILDING MASONRY	Jan-97	30,420	2,028	15	2,028		9,126		64
65	OUTSIDE OF BUILDING MASONRY	Jan-97	73,980	4,932	15	4,932		22,194		65
66	OUTSIDE OF BUILDING MASONRY	Jan-97	59,202	3,947	15	3,947		17,761		66
67	WARD MASONRY & REPAIRS	Aug-97	100,260	6,684	15	6,684		23,394		67
68	WARD MASONRY & REPAIRS	Sep-97	70,650	4,710	15	4,710		16,485		68
69	1ST FLOOR RENOVATION	Oct-97	9,458	631	15	631		2,207		69
70	TOTAL (lines 4 thru 69)		\$ 6,166,382	\$ 82,258		\$ 82,258	\$	\$ 5,451,130		70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 6,166,382	\$ 82,258		\$ 82,258	\$	\$ 5,451,130	1
2	1ST FLR RENOVATION	Nov-97	70,229	4,682	15	4,682		16,387	2
3	WIRING & LIGHTING SYSTEM	Nov-97	3,954	395	10	395		1,384	3
4	AUDIO CABLE WALL JACKS	Nov-97	295	20	15	20		69	4
5	DOOR HARDWARE & LOCKS	Nov-97	522	35	15	35		122	5
6	PHASE I WINDOW TREATMENT	Nov-97	10,755	1,075	10	1,075		3,764	6
7	1ST FLR RENOVATION	Dec-97	75,552	5,037	15	5,037		17,629	7
8	WARD MASONRY REPAIRS	Dec-97	60,519	4,035	15	4,035		14,121	8
9	2ND FLR ASBESTOS REMOVAL	Jan-98	5,810	387	15	387		1,356	9
10	METAL & ROOFING WORK	Jan-98	12,520	835	15	835		2,921	10
11	CURTAINS & MINI BLINDS, CAFETERIA BLNDS	Feb-98	8,212	411	20	411		1,437	11
12	ELECTRICAL WIRING & LIGHTING SYSTEM	Feb-98	12,349	1,235	10	1,235		4,322	12
13	DATA CABLING	Feb-98	3,919	261	15	261		914	13
14	ELECTRICAL WIRING & LIGHTING SYSTEM	Feb-98	1,636	164	10	164		573	14
15	1ST FLR PAINTING & FLR COVERING	Mar-98	10,070	671	15	671		2,350	15
16	INSTALL PRIVACY CURTAINS	Mar-98	5,870	293	20	293		1,027	16
17	DOOR HARDWARE & LOCKS	Mar-98	11,248	750	15	750		2,624	17
18	INSTALL PRIVACY CURTAINS	Apr-98	1,996	100	20	100		349	18
19	1ST FLR REMODELING PHASE II	Apr-98	92,508	9,251	10	9,251		32,378	19
20	SIGNAGE PHASE I & II	Apr-98	1,203	80	15	80		281	20
21	TELEPHONE UPDATE	Apr-98	227	15	15	15		53	21
22	LIGHTING FIXTURES	Apr-98	146	15	10	15		51	22
23	MASONRY REPAIRS	May-98	71,682	4,779	15	4,779		16,726	23
24	PHASE II WINDOW TREATMENT	May-98	3,598	360	10	360		1,259	24
25	1ST FLR REMODELING PHASE II	May-98	90,688	6,046	15	6,046		21,161	25
26	REMOVE ASBESTOS TILES	Jun-98	13,056	870	15	870		3,046	26
27	INSTALL PRIVACY CURTAINS	Jun-98	5,376	269	20	269		941	27
28	SIGNAGE	Jun-98	2,856	190	15	190		666	28
29	PRIVACY CURTAINS FOR RESIDENTS	Jul-98	2,508	125	20	125		314	29
30	INSTALL FENCE	Jul-98	2,055	137	15	137		343	30
31	SIGNAGE	Jul-98	1,390	93	15	93		232	31
32	LIGHTING SYSTEM	Aug-98	526	53	10	53		131	32
33	FLAME RETARDANT WINDOW TREATMENT	Sep-98	5,531	553	10	553		1,383	33
34	TOTAL (lines 1 thru 33)		\$ 6,755,187	\$ 125,480		\$ 125,480	\$	\$ 5,601,443	34

**Improvement type must be detailed in order for the cost report to be considered complete.

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 6,755,187	\$ 125,480		\$ 125,480	\$	\$ 5,601,443	1
2	1ST FLR REMODELING	Sep-98	61,819	4,121	15	4,121		10,303	2
3	ELECTRICAL WIRING & LIGHTING	Oct-98	14,806	1,481	10	1,481		3,701	3
4	DUCTWORK MODIFICATIONS	Nov-98	3,228	323	10	323		807	4
5	FIREPROOF ELEVATOR, MECH RM. GENERATOR & BOILER	Dec-98	5,800	580	10	580		1,450	5
6	NEW WATER TREATMENT	Dec-98	3,792	379	10	379		948	6
7	PULL SWITCH & NIGHT LIGHTS	Jan-99	10,735	1,074	10	1,074		2,684	7
8	SEWAGE PUMP	Jan-99	3,242	324	10	324		811	8
9	REPLACE CONVENT ROOF	Feb-99	20,000	2,000	10	2,000		5,000	9
10	LIGHTING FIXTURES	Mar-99	354	35	10	35		88	10
11	ROOF REPAIRS	Mar-99	5,450	545	10	545		1,363	11
12	SUMP PUMP	Mar-99	1,466	147	10	147		367	12
13	DOOR FIRE ALARM	Apr-99	6,676	668	10	668		1,669	13
14	GARBAGE COMPACTOR	Jul-99	6,337	634	10	634		951	14
15	FIRE PROTECTION SURVEY	Aug-99	900	90	10	90		135	15
16	MAGNETIC DOOR HOLDERS	Oct-99	2,100	210	10	210		315	16
17	BOILER REPAIR	Dec-99	1,432	143	10	143		215	17
18	REPLACE 2ND & 3RD FLR WINDOWS	Jan-00	4,700	470	10	470		705	18
19	DRAPES & BLINDS	Mar-00	19,066	1,907	10	1,907		2,860	19
20	REPLACE 2ND & 3RD FLR WINDOWS	May-00	9,463	946	10	946		1,419	20
21	REPLACE 2ND & 3RD FLR WINDOWS	Jun-00	9,443	944	10	944		1,416	21
22	INSTALL WROUGHT IRON FENCE	Aug-00	4,737	158	15	158		158	22
23	INSTALL PLUMBING FOR 3 TUBS	Dec-00	5,200	173	15	173		173	23
24	PAINT JOB FOR 2ND AND 3RD FLRS	Dec-00	3,807	381	5	381		381	24
25	INSTALL AWNINGS	Mar-01	3,000	100	15	100		100	25
26	INSTALL CHAIN LINK FENCE	May-01	1,831	61	15	61		61	26
27	INSTALL AWNINGS	Jun-01	4,600	153	15	153		153	27
28	PAINT JOB FOR HALLWAYS	Jun-01	634	63	5	63		63	28
29	PAVING	Jan-72	7,555		8			7,555	29
30	SIDEWALKS	Jan-74	2,834		15			2,834	30
31	REPAVING	Jan-75	3,640		8			3,640	31
32	BLACKTOP	Jan-79	9,700		8			9,700	32
33	GATE ENTRANCE	Jan-86	986		3			986	33
34	TOTAL (lines 1 thru 33)		\$ 6,994,520	\$ 143,589		\$ 143,589	\$	\$ 5,664,454	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)								
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.								
1	2	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward	\$ 6,994,520	\$ 143,589		\$ 143,589		\$ 5,664,454	1
2	TARRING & SEALCOATING	679		8			679	2
3	CONCRETE	15,525		20				3
4	SIDEWALK	4,285		15				4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 7,015,009	\$ 143,589		\$ 143,589		\$ 5,665,133	34

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 949,275	\$ 70,623	\$ 70,623	\$		\$ 516,206	71
72	Current Year Purchases	71,147	3,977	3,977			3,977	72
73	Fully Depreciated Assets	717,069					717,069	73
74								74
75	TOTALS	\$ 1,737,491	\$ 74,600	\$ 74,600	\$		\$ 1,237,252	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 8,764,824	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 218,189	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 218,189	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,902,385	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Architectural Consulting	\$ 18,113	92
93			93
94			94
95		\$ 18,113	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2002 \$ _____

13. /2003 \$ _____

14. /2004 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist		hrs	\$		\$
2	Licensed Speech and Language Development Therapist		hrs								2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs								4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts								9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL			\$		\$	\$		\$		14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 522,713	\$	1
2	Cash-Patient Deposits	48,718		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,104,797		3
4	Supply Inventory (priced at)	32,543		4
5	Short-Term Investments	3,271,070		5
6	Prepaid Insurance	63,943		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,043,784	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	79,990		12
13	Land			13
14	Buildings, at Historical Cost	7,040,939		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,711,560		16
17	Accumulated Depreciation (book methods)	(6,902,740)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Const. Work in Progress</u>	18,113		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,947,862	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,991,646	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 373,912	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	48,718		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	394,975		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Due to third parties</u>	10,000		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 827,605	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Security Deposits</u>	23,289		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 23,289	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 850,894	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 7,140,752	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,991,646	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 7,365,841	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 7,365,841	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(47,645)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Net Change in Unreal.Gain on Invest.	(241,648)	15
16	Other (describe) Contrib. To Capital & Others	64,204	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (225,089)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 7,140,752	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

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Facility Name & ID Number St Joseph Home of Chicago

0045427

Report Period Beginning: 07/01/00

Ending:

06/30/01

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 7,595,177	1
2	Discounts and Allowances for all Levels	(541,193)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,053,984	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,997	12
13	Barber and Beauty Care	7,403	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	95	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 9,495	23
	D. Non-Operating Revenue		
24	Contributions	568,049	24
25	Interest and Other Investment Income***	178,016	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 746,065	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. Inc.	93,422	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 93,422	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,902,966	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,561,698	31
32	Health Care	3,647,848	32
33	General Administration	2,422,676	33
	B. Capital Expense		
34	Ownership	218,189	34
	C. Ancillary Expense		
35	Special Cost Centers	4,289	35
36	Provider Participation Fee	95,911	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,950,611	40
41	Income before Income Taxes (line 30 minus line 40)**	(47,645)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (47,645)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number St Joseph Home of Chicago# 0045427Report Period Beginning: 07/01/00Ending: 06/30/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,832	2,176	\$ 71,136	\$ 32.69	1
2	Assistant Director of Nursing	1,951	2,080	57,237	27.52	2
3	Registered Nurses	39,365	43,619	972,770	22.30	3
4	Licensed Practical Nurses	26,925	28,895	474,348	16.42	4
5	Nurse Aides & Orderlies	104,878	115,981	1,151,070	9.92	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	1,504	1,504	39,411	26.20	7
8	Rehab/Therapy Aides	3,756	4,084	51,573	12.63	8
9	Activity Director	2,000	2,120	32,213	15.19	9
10	Activity Assistants	11,948	13,051	125,309	9.60	10
11	Social Service Workers	3,620	4,089	93,730	22.92	11
12	Dietician	1,936	2,160	45,326	20.98	12
13	Food Service Supervisor	9,368	10,543	110,054	10.44	13
14	Head Cook					14
15	Cook Helpers/Assistants	23,914	27,005	207,925	7.70	15
16	Dishwashers					16
17	Maintenance Workers	9,369	12,598	198,703	15.77	17
18	Housekeepers	20,482	23,386	185,768	7.94	18
19	Laundry	11,312	13,023	105,096	8.07	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	5,768	6,360	185,189	29.12	22
23	Office Manager					23
24	Clerical	15,957	16,382	210,937	12.88	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,931	2,171	22,867	10.53	31
32	Other Health C: <u>Secretary</u>	1,676	2,105	26,492	12.59	32
33	Other(specify) <u>Central Supply</u>	1,928	2,160	24,234	11.22	33
34	TOTAL (lines 1 - 33)	301,420	335,492	\$ 4,391,388 *	\$ 13.09	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	192	\$ 7,700	9-5	35
36	Medical Director	65	7,200	1-5	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	44	1,660	11-5	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	301	\$ 16,560		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
			\$	Workers' Compensation Insurance		\$	IDPH License Fee	\$
				Unemployment Compensation Insurance		5,634	Advertising: Employee Recruitment	6,288
				FICA Taxes		316,291	Health Care Worker Background Check (Indicate # of checks performed <u>29</u>)	826
				Employee Health Insurance		338,874	City of Chicago	1,220
				Employee Meals			Secretary of State	156
				Illinois Municipal Retirement Fund (IMRF)*				
				Employee Dental & Vision		49,443		
				401K Match		64,752		
				Life Insurance		24,821		
				Employee Awards		6,723		
				Employee Others		33,180		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$				Less: Public Relations Expense	(
B. Administrative - Other							Non-allowable advertising	(
							Yellow page advertising	(
Description			Amount					
Richard Bracken			\$ 98,244					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 98,244	TOTAL (agree to Schedule V, line 22, col.8)		\$ 839,718	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 8,490
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Dr. Salazar	Medical Director		\$ 7,200			\$	Out-of-State Travel	\$
Quality Care Consultants	Activity		1,535					
Helen Donovan	Activity		125					
Karen Hemzacek	Dietician		7,700				In-State Travel	468
Vedder Price	Legal fees		10,558					
Katten,Muchin & Zavis	Legal fees		1,931					
FR & R	Billing Services		118,698				Seminar Expense	714
Healthcare Directions	Billing Services		28,021					
Ernst & Young	Audit		27,500					
Healthcare Financials	Assessment fee-Prov.Tx		3,050					
Butts & Hyatt	Exp.Audit-Coll fee-dupl.pay		1,326				Entertainment Expense	(
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 207,644	TOTAL		\$	TOTAL	\$ 1,182

* Attach copy of IMRF notifications

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report? yes
If YES, give association name and amount. HRA, LSN, AAHSA
- (3) Did the nursing home make political contributions or payments to a political action organization? no If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 10 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 55,178 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 95,911
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ _____ Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? no
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? yes
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? yes
Firm Name: Ernst & Young The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? no If no, please explain. will be sent under separate cover
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? yes
Attach invoices and a summary of services for all architect and appraisal fees.